MDR Tracking Number: M5-04-2646-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 4-22-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

The mechanical traction, chiropractic manipulation, and hot-cold packs from 7-21-03 through 9-15-03 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were not the only fees involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 7-29-04 the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

CPT code 97012 for dates of service 4-25-03, 5-9-03 and 5-22-03 was denied with codes of "D" and "O". Per Rule 133.304(c): The insurance carrier must provide correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason for the insurance carrier's actions. **Recommend reimbursement of $33.00.**

CPT code 99213 for dates of service 4-25-03, 5-9-03 and 5-22-03 was denied with codes of "D" and "O". Per Rule 133.304(c): The insurance carrier must provide correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason for the insurance carrier's actions. **Recommend reimbursement of $124.50.**

CPT codes 99213 for date of service 6-30-03 was denied with an R. According to the TWCC 21 on file with TWCC the insurance carrier is accepting lumbar strain as the compensable injury. The S.O.A.P. notes submitted by the provider indicate that "lumbar spine pain" is the chief complaint. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant

information to support delivery of service. **Therefore, reimbursement is recommended in the amount of $41.50.**

CPT codes 97012 for date of service 6-30-03 was denied with an R. According to the TWCC 21 on file with TWCC the insurance carrier is accepting lumbar strain as the compensable injury. The S.O.A.P. notes submitted by the provider indicate that "lumbar spine pain" is the chief complaint. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service**. Reimbursement is recommended in the amount of $11.00.**

CPT code 98941 for date of service 10-20-03 was denied with code of "L" – not treating doctor. However, the provider listed as the treating doctor was also the doctor who performed these services. The respondent provided no further rationale. **Reimbursement of $41.50 is recommended**.

CPT code 97012 for dates of service 10-20-03 and 11-3-03 was denied with code of "L". However, the provider listed as the treating doctor was also the doctor who performed these services. The respondent provided no further rationale. **Reimbursement of $22.00 is recommended.**

CPT code 99213 for date of service 11-3-03 was denied with code of "L". However, the provider listed as the treating doctor was also the doctor who performed these services. The respondent provided no further rationale. **Reimbursement of $41.50 is recommended**.

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003; in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202(c); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 4-25-03 through 11-3-03 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 29th day of October, 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

DA/da

July 12, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-2646-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
------ Case #:

------ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ------ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ------ for independent review in accordance with this Rule.

------ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ------ external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ------ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ------ for independent review. In addition, the ------ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 39 year-old male who sustained a work related injury on ------. The patient reported that while at work he injured his back while lifting and moving pallets. X-Rays of the patient's lumbar spine on 4/14/01 showed minimal degenerative changed lumbar spine. A MRI performed on 5/31/01 was reported to have revealed a broad based disc protrusion at L4-5. A CT scan of the lumbar spine (discography) performed on 1/23/04 indicated an annular tear with extravasation of contrast posteriorly at the L4-5 level. The diagnoses for this patient have included lumbar sprain/strain, lumbar degenerative disc disease, and lumbar HNP. Treatment for this patient's condition has included physical therapy, lumbar facet injections, lumbar facet rhizotomy, neuromuscular stimulator and medications.

Requested Services

Mechanical traction, chiropractic manipulation, and hot/cold packs from 7/21/03 through 9/15/03.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. SOAP notes 4/25/03 – 11/3/03
2. MMI Impairment Rating 2/4/04
3. CT of the lumbar spine report 1/23/04

Documents Submitted by Respondent:

1. Independent Review Organization Summary 6/2/04
2. X-Ray report 4/14/01
3. MRI report 5/31/01
4. Office notes Dr. V, 4/26/01 –5/25/01

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

Rationale/Basis for Decision

The ------ chiropractor reviewer noted that this case concerns a 39 year-old male who sustained a work related injury to his back on ------. The ------ chiropractor reviewer also noted that the diagnoses for this patient have included lumbar sprain/strain, lumbar degenerative disc disease, and lumbar HNP. The ------ chiropractor reviewer further noted that the treatment for this patient's condition has included physical therapy, lumbar facet injections, lumbar facet rhizotomy, neuromuscular stimulator and medications. The ------ chiropractor reviewer explained that the treatment this patient received from 7/21/03 through 9/15/03 was medically necessary and reasonable, although it did not result in significant improvement in his condition. Therefore, the ------ chiropractor consultant concluded that the Mechanical traction, chiropractic manipulation, and hot/cold packs from 7/21/03 through 9/15/03 were medically necessary to treat this patient's condition.

Sincerely,
